CHAPTER 2

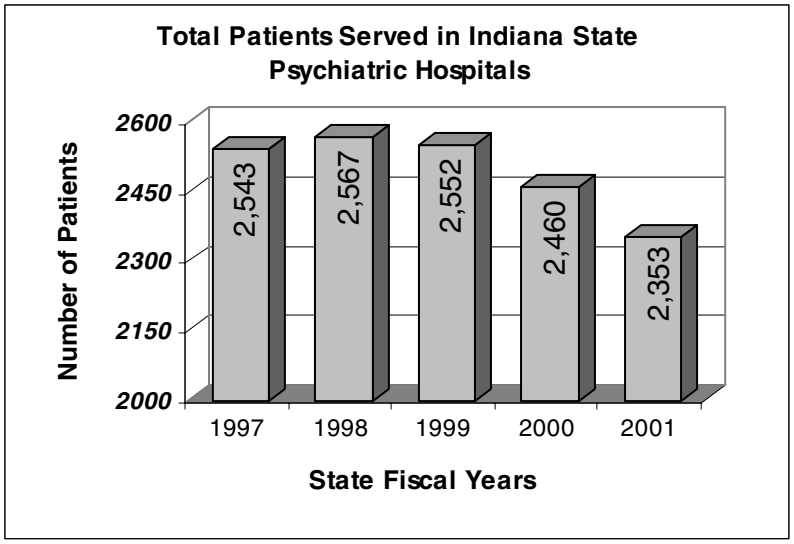
The Hoosier Assurance Plan Community Services, the State Psychiatric Hospitals, and Quality Assurance

The Hoosier Assurance Plan

The Hoosier Assurance Plan (HAP) is the primary vehicle by which the Division of Mental Health and Addiction funds community mental health and addiction services. The HAP replaced "deficit" and grants-in-aid funding with a methodology that directly funds eligible consumers in targeted populations. As established by the Indiana legislature, the HAP is designed to support and manage the delivery of behavioral healthcare services to a targeted, low-income population who have clearly identified needs.

The 1994 closing of Central State Hospital signaled the beginning of a strong movement from hospital to community-based care in Indiana. Figure 2.1 shows decreases in the number of patients being served in Indiana state psychiatric hospitals since 1997 and Figure 2.2 shows substantial increases in the number of consumers who are utilizing community services.

Figure 2.1



Source: Larue D. Carter Memorial Hospital; Evansville State Hospital; Evansville Psychiatric Children's Center; Logansport State Hospital; Madison State Hospital; Richmond State Hospital

In 1996, DMHA-certified Managed Care Providers (MCPs) who had contracts to serve persons with chemical addictions and gambling disorders began enrolling clients in HAP. Enrollments in this first year also began for persons with chronic addictive disorders or serious mental illness who are deaf or hard of hearing. The following year, MCPs that were certified to offer services to children and adolescents with serious emotional disturbance began enrolling clients. Services designed to prevent the use of alcohol, tobacco, and other drugs by children between the ages of 10 and 14 also began at that time. Beginning with State Fiscal Year 1999, full implementation of HAP occurred when contracts were executed with MCPs to provide services to adults with serious mental illness.

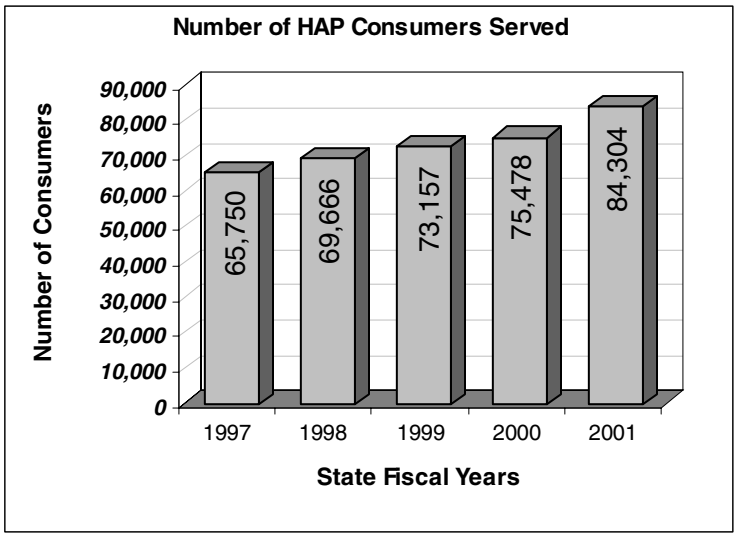
Community Provision of Mental Health and Addiction Services

Within the Hoosier Assurance Plan, the DMHA strives to insure access to, and availability of, quality services to all eligible citizens. For this reason, funding for HAP is allocated annually to providers and regions of the state based on analysis of actual service data and estimated mental illness and addictions prevalence figures derived from actuarial data. DMHA certifies and contracts with Managed Care Providers (MCPs), which are nonprofit organizations that are responsible for providing mental health and

chemical addiction services. During the 2000-2001 biennium, there were 33 MCPs providing services statewide. The MCPs receive a prospective capitation payment as they enroll eligible consumers, in exchange for which the provider assumes the responsibility of meeting the client's needs from the date of enrollment through the end of a fiscal year.

A significant source of increased funding has been the Medicaid Rehabilitation Option (MRO), which allows federal Medicaid funds to pay for certain behavioral health services if the state contributes a percentage of the total in matching funds.

Figure 2.2



Source: DMHA MERR databases and Community Services Data System

The Hoosier Assurance Plan employs certain managed care principles in purchasing services on behalf of Indiana citizens. The creation of HAP introduced the idea of an array of services, which refers to the range of services that are provided by MCPs. Although DMHA provides general oversight and control of the funds it distributes, direct responsibility for maintaining the full array of care for eligible consumers is delegated to the MCPs. These providers perform the gatekeeping role of qualifying, evaluating, enrolling, and monitoring consumers in the mental health care system. They may either administer care directly or subcontract services with other care providers.

The Hoosier Assurance Plan is not intended to directly serve the total Indiana population in need of mental health and addiction services. Rather, HAP serves only that portion of the population in greatest need of public support. Therefore, HAP funds are targeted to low-income persons, defined as those at or below 200% of the federal poverty level. However, HAP is not an entitlement, as it is limited by the availability of resources. HAP allows the DMHA to have flexibility in targeting services to specific populations. Indiana Statute guides the DMHA in this process, but targeting is also guided by the special needs of some populations (e.g., the deaf population), by federal requirements (e.g., addicted women with dependent children), or by funding opportunities. The four primary populations designated by Indiana Statute are:

- Adults with Serious Mental Illness (SMI)
- Children with Serious Emotional Disturbance (SED)
- Persons with Chronic Addiction (SA)
- Persons with a Compulsive Gambling Disorder (GAM)

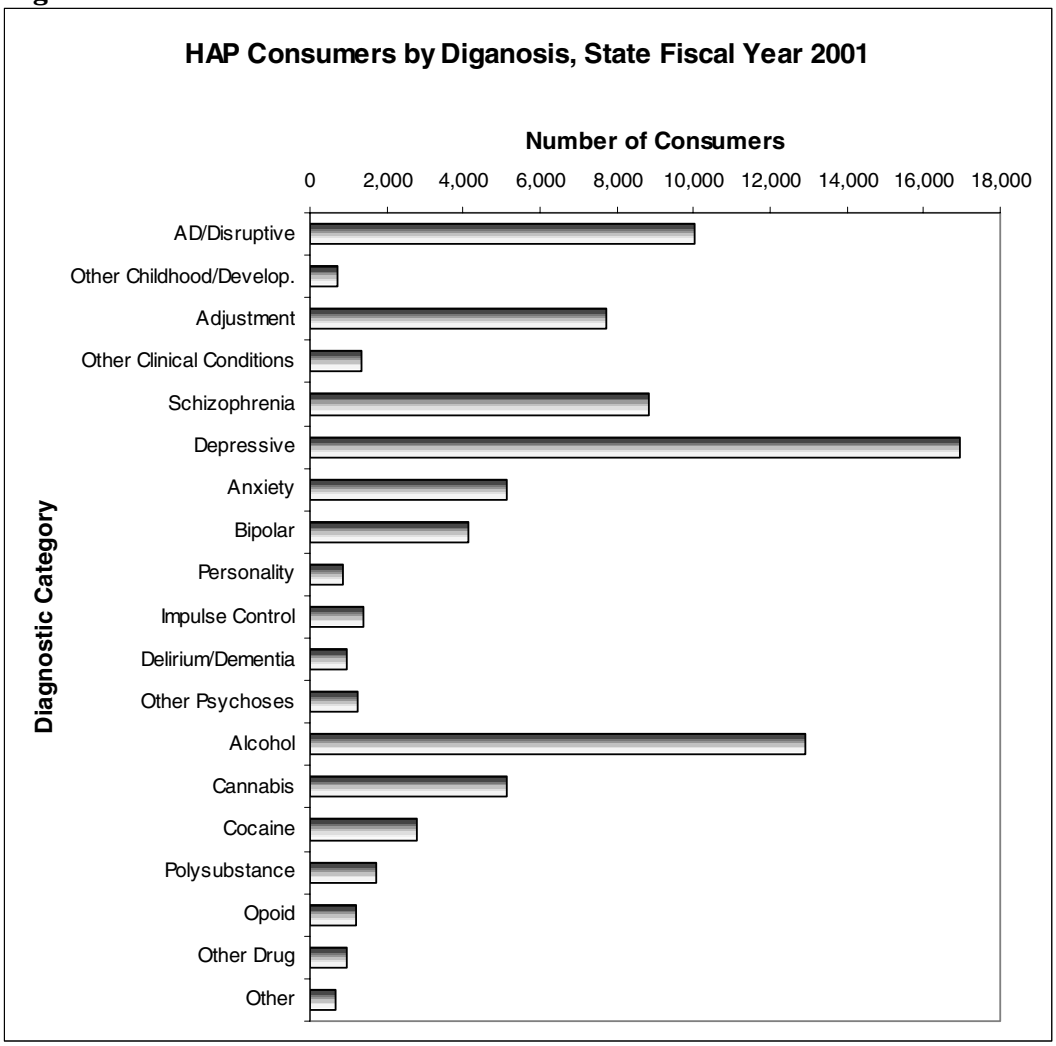
Services to the deaf, considered a fifth population, have been carved out and go to specific contractors. The DMHA also serves and reports on chronically addicted women who are pregnant or who have dependent children, and on individuals who are receiving methadone treatment.

Characteristics of Consumers in the Community

The number of children and adolescents with a serious emotional disturbance (SED) who are being served by the Hoosier Assurance Plan has risen markedly since SFY 1996, from approximately 14,500 to 21,500. The same increases are not as notable for adults with serious mental illness (SMI). In SFY 1996, around 34,800 SMI consumers were served, while in SFY 2001, around 38,300 were served. The rise in the number of children served is attributed to state, parental, and advocate efforts to build greater awareness of community centers and the services that are offered to children. There were approximately 6,500 HAP consumers receiving substance abuse (SA) services in SFY 1996, and by SFY 2001 that number had increased to nearly 24,400.

In SFY 1997, 31 HAP consumers received services for gambling addiction, and by SFY 2001 that number has risen to 125. The Indiana Problem Gambling Taskforce was established by DMHA and is charged with the task of developing an efficient method for disseminating problem gambling information throughout the state of Indiana. Services offered include a toll-free referral line and a full array of care including case management, inpatient care, intensive outpatient services, linkage with self-help groups, and financial management counseling. Twenty-four state endorsed providers currently offer compulsive gambling treatment endorsement.

Figure 2.3

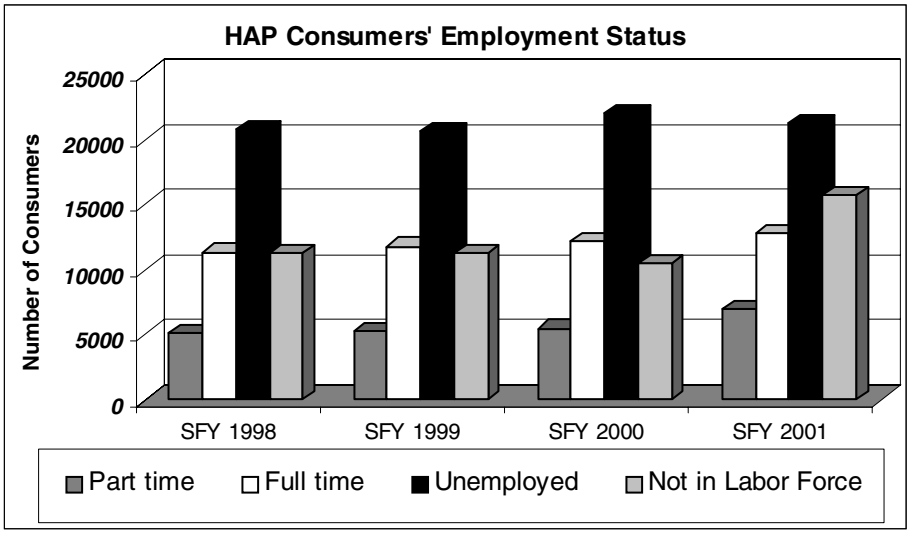


Source: Community Services Data System

Figure 2.3 (above) shows diagnostic categories for consumers receiving community mental health and addiction services, based upon diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association; 2000). For adults, services are most often received for depressive disorders, schizophrenia, and alcohol abuse.

As shown in Figure 2.4, most HAP consumers are unemployed or not in the labor force, which reflects the eligibility criteria of HAP that consumers be at or below 200% of the poverty level. Consumers who are "not in the labor force" are defined as people who have not looked for work during the last 30 days, or who are homemakers, students, disabled, retired, or in a hospital.

Figure 2.4



Source: DMHA MERR databases and Community Services Data System

The Division offers several services, in collaboration with other state entities, designed to help HAP consumers enter the job market. Two services offered are:

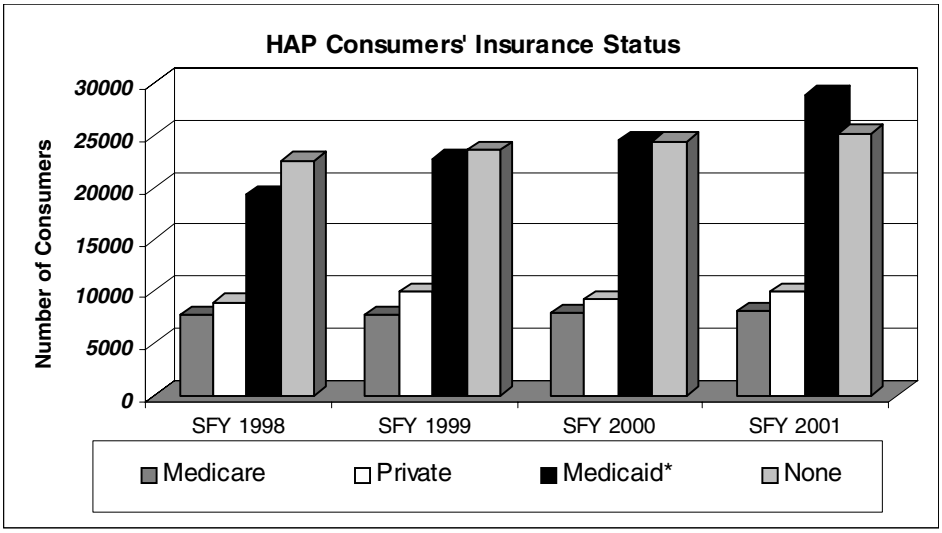
Supported Employment: Indiana's mental health system has been very active in building supported employment programs. Required state matching funds provided by DMHA enabled the Office of Vocational Rehabilitation (OVR) to provide funds to assist agencies with establishment grants. By the end of 2001, twenty-six community mental health centers (CMHCs) had established supported employment services. In 1990, only one CMHC offered such services.

Data collected by the Indiana Office of Vocational Rehabilitation shows that enrollment in supported employment programs averages 772 individuals per year since 1999. Researchers at Ball State University have been collecting data from supported employment programs throughout Indiana, which shows that about 55% of those who enter a supported employment program will secure employment. When applying that percentage to the data provided by OVR, findings are that during the period from 1999 to 2001 an estimated 1,274 persons with mental illness were able to secure employment through supported employment programs.

Welfare to Work: The DMHA implemented a memorandum of understanding with the Department of Workforce Development (DWD) to implement the Welfare to Work program. Through this cooperative effort, eligible individuals can access many workforce development programs and services. These include

community service or work experience programs, employment readiness and job placement, on-the-job training, job retention or support services, and wage subsidies.

Figure 2.5

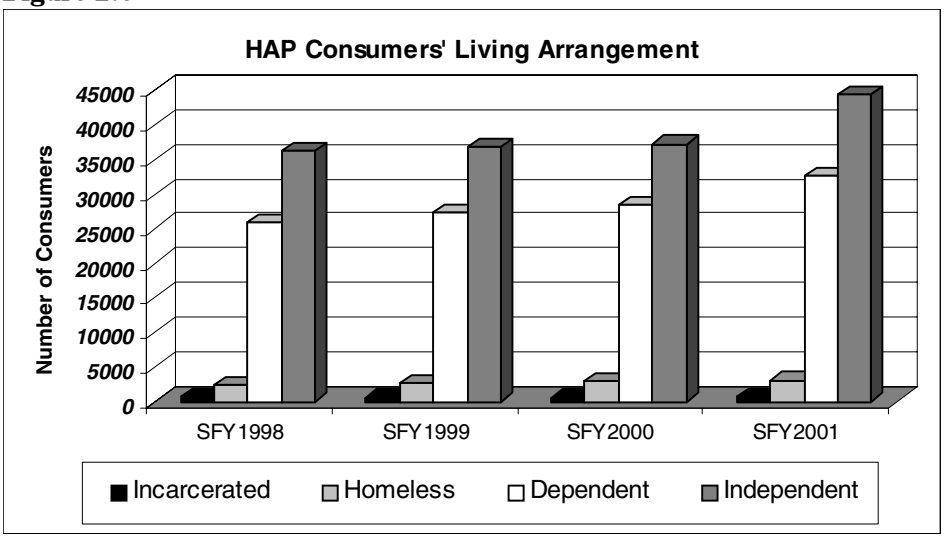


**As reported to the DMHA in the CSDS system HAP enrollment data*
Source: DMHA MERR databases and Community Services Data System

The limited medical insurance resources of HAP consumers are related to their poverty-level and under-employed characteristics. As shown in Figure 2.5, many HAP consumers have no medical insurance, a trend that has steadily increased since 1998. The number of HAP consumers utilizing Medicaid has risen over the four years shown, while the number of HAP consumers utilizing private insurance and Medicare appears to be fairly steady. The rise in Medicaid consumers is due to the expansion of Medicaid programs and the expansion of MRO programs specifically targeting Medicaid to CMHCs.

Figure 2.6 shows the living arrangement of HAP consumers over a four-year period. Independent living is defined as living without routine or planned supportive community service in order to maintain independence in the living situation. Dependent living includes consumers who live in a residential setting that may or may not provide treatment. To assist homeless consumers, DMHA works with the Mental Health Services for Homeless Persons with Mental Illness Fund (PATH), a federal housing program.

Figure 2.6



Source: DMHA MERR Databases and Community Services Data System

PATH offers services that meet the special challenges presented by homeless individuals who are mentally ill. One way this population is served is through Shelter Plus Care (S+C), a U.S. Department of Housing and Urban Development sponsored program that links the provision of housing supports with the provision of treatment services. In S+C projects, the CMHC

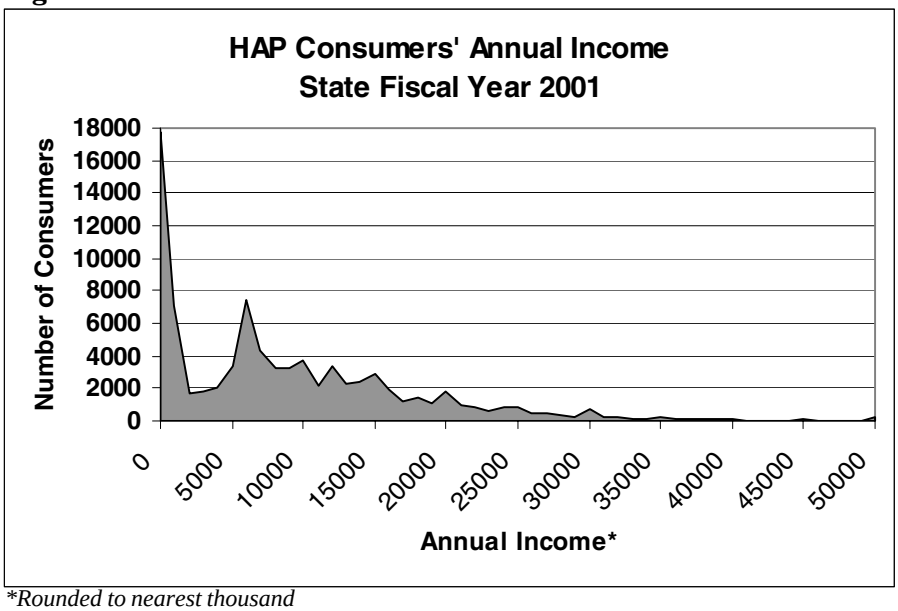
receives rental subsidies that are "matched" by an equal value of treatment services. These projects are designed to serve individuals who are homeless and have a mental illness, are substance abusers, or are HIV positive. Four CMHCs currently have S+C projects through DMHA. They are located in East Chicago, Ft. Wayne, Indianapolis, and Lawrenceburg.

"John" has been homeless for 15 years, most recently living under a bridge in Indianapolis. After being connected to a local Shelter Plus Care program he was able to move into his own apartment. Since September he has lived in a studio apartment and is beginning to build the trappings of a normal life. A recent visit to his home found a plant cutting in a jar on the window sill. He is nurturing the plant waiting for it to take root, a symbol of the new stability and hope that a home has afforded him. "It was a pleasure to meet this man and to hear his excitement about his apartment and his appreciation of shelter and safety."

Submitted by DMHA personnel

As shown in Figure 2.7, most HAP consumers have little or no income. More than one-third (39.8%) have earnings below $5000 annually, with nearly 21% reporting no annual income. The income criteria for the HAP states that individuals must have an income at or below 200% of the federal poverty level (FPL), an amount that increases dependent upon family size and that changes annually. For the year 2001, a family of three was considered to be in poverty if the annual household income was $14,630 or less. To meet HAP income criteria, the income requirement would be $29,260 or less, which is twice the federal poverty level amount (referred to as 200% of the FPL). As family size increases, the amount of income also increases, and Figure 2.7 reflects these increased annual income amounts which are associated with large families. For more information, visit the U.S. Census Bureau website at *http://www.census.gov/* or visit the U.S. Department of Health and Human Services (HHS) website at *http://aspe.hhs.gov/poverty/poverty.htm* and read about the "poverty guidelines," which are used by the Indiana Division of Mental Health and Addiction.

Figure 2.7



**Rounded to nearest thousand*
Source: DMHA MERR databases and Community Services Data System

STATE PSYCHIATRIC HOSPITALS

The state is served by the following six state psychiatric hospitals:

- Larue D. Carter Memorial Hospital, Indianapolis, IN
- Evansville Psychiatric Children's Center, Evansville, IN
- Evansville State Hospital, Evansville, IN
- Logansport State Hospital, Logansport, IN
- Madison State Hospital, Madison, IN
- Richmond State Hospital, Richmond, IN

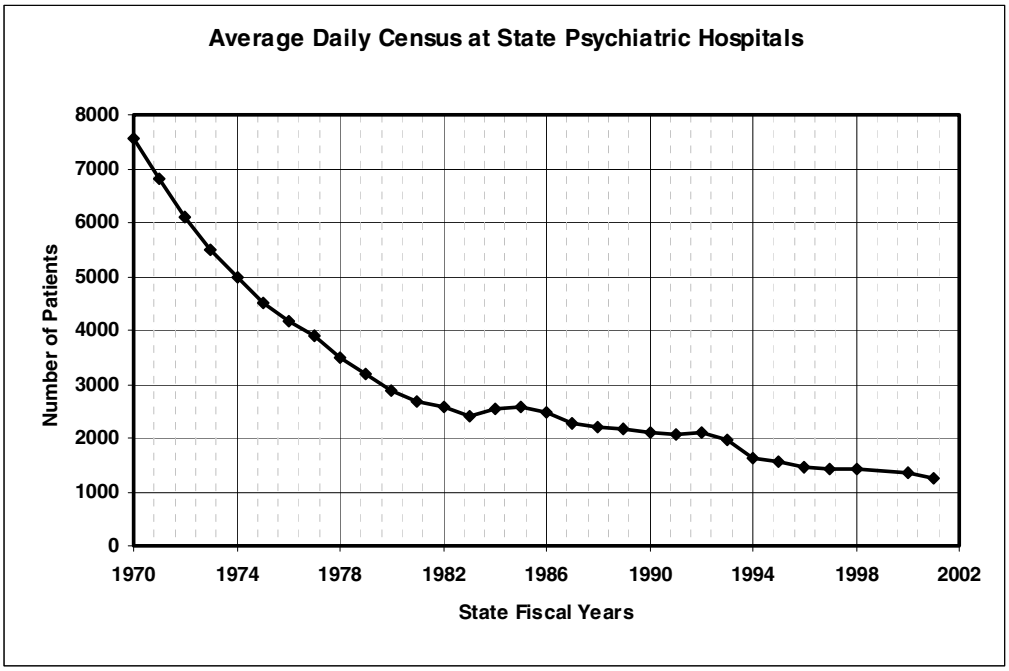
The state hospital system serves adults of all ages with serious mental illness who may or may not have chronic addictive disorders, adults with only chronic addictive disorders, adults who are deaf and mentally ill, adults who are both developmentally disabled and mentally ill, and children and adolescents with serious emotional disturbance.

Services are provided to persons with mental illness who are dangerous to themselves and/or others, and to persons who are gravely disabled. These individuals have an illness that does not respond to short-term intervention in the community. Patients are admitted to a state psychiatric hospital only after a screening by a community mental health center "gatekeeper," who is responsible for providing case management to the patient in both the hospital and community. Gatekeepers are also responsible for facilitating a patient's transition from the hospital back to the community or other appropriate setting. State psychiatric hospitals have implemented transitional care services to help patients make a smooth transition to community living, and staff for these services work with the patient's gatekeeper on treatment planning and discharge.

The mission of the state psychiatric hospital system is to strive for excellence in quality of service and competence of staff to ensure that the delivery of services is consistent with consumer needs and the needs of their families. Goals include: 1) maintaining a safe, comfortable, and supportive environment; 2) providing services in a respectful manner; 3) promoting the dignity and rights of consumers; and 4) facilitating consumers' return to the community. All hospitals have implemented the service line management model, which is a planning/management system that facilitates and coordinates multiple services to meet identified needs of patients. Core services at the state hospitals are individualized and may include stabilization of symptoms through psychopharmacology, management of medical problems, individual and group therapy, patient education, family education and counseling, academic and skills training, rehabilitation and recreation therapy, vocational training, and supported employment.

Figure 2.8 shows a substantial decline in the average daily census in the state psychiatric hospitals since the 1970s.

Figure 2.8



Source: WANG, Decision Support System, DMHA MERR databases, and Community Services Data System

Characteristics of People in the State Psychiatric Hospitals

In SFY 2000, a total of 2,460 persons received care through the state psychiatric hospitals, and in SFY 2001, a total of 2,353 were served. Figure 2.9, the patient census of adults as of every June 30 of 1998 to 2001 (the last day of each state fiscal year), shows the major diagnostic categories for persons present in the state psychiatric hospitals.

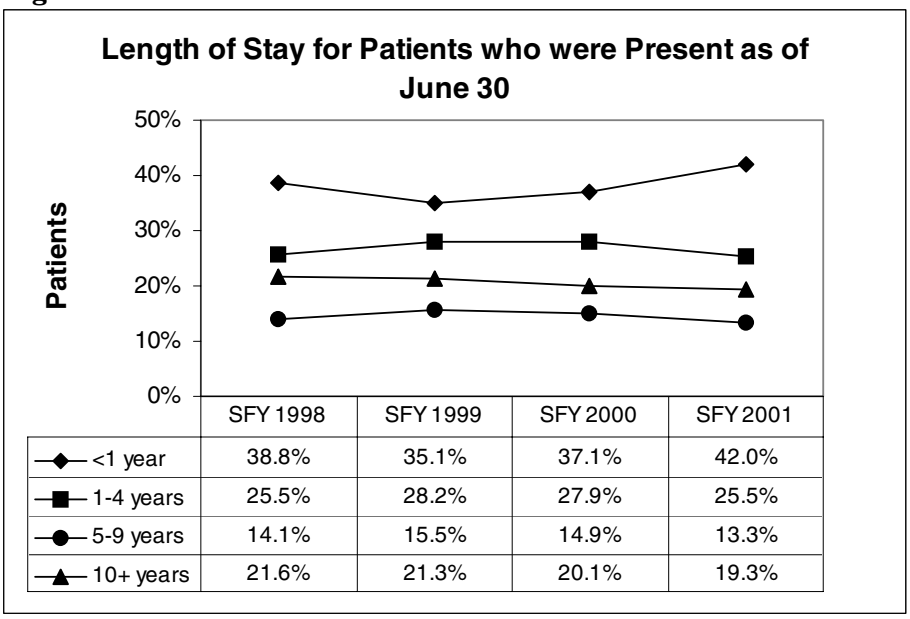
Figure 2.9

INDIANA STATE PSYCHIATRIC HOSPITALS Patient Census by Mental Illness, Developmental Disability, and Chemical Addiction Diagnosis Snapshots: June 30 of 1998, 1999, 2000, 2001												
	June 1998			June 1999			June 2000			June 2001		
MAJOR DIAGNOSTIC CATEGORIES*---->	MI	DD	CA	MI	DD	CA	MI	DD	CA	MI	DD	CA
Logansport State Hospital	314	58	7	319	55	7	303	49	0	282	46	0
Evansville State Hospital	222	62	6	206	57	8	167	59	0	144	54	0
Larue D. Carter Memorial Hospital	131	1	4	134	2	1	124	0	0	107	0	0
Richmond State Hospital	219	32	42	218	28	58	212	26	35	206	29	40
Madison State Hospital	214	48	26	220	42	24	174	64	18	166	52	18
Evansville Psychiatric Children's Center	25	0	0	23	1	0	19	0	0	21	0	0
Delta Services	21	0	0	18	0	0	18	0	0	20	0	0
Totals by Diagnosis	1146	201	85	1138	185	98	1017	198	53	946	181	58
State Totals	1432			1421			1268			1185		

*Legend: MI = Serious Mentally Ill, DD=Developmentally Disabled, and CA=Chemical (substance) Abuse.
Source: WANG and Decision Support System

Figure 2.10 shows patient length of stay at state psychiatric hospitals for all patients who were present as of every June 30 for 1998 through 2001. Several interesting trends are shown in this figure. First, for patients who were present at the hospital for any given June 30, it is shown that the percentage of those who have a hospital length of stay less than one year is on the rise since SFY 1999. In other words, since SFY 1999, there are more patients with a shorter length of stay.

Figure 2.10



	SFY 1998	SFY 1999	SFY 2000	SFY 2001
<1 year	38.8%	35.1%	37.1%	42.0%
1-4 years	25.5%	28.2%	27.9%	25.5%
5-9 years	14.1%	15.5%	14.9%	13.3%
10+ years	21.6%	21.3%	20.1%	19.3%

Source: WANG and Decision Support System

The second interesting trend shown in Figure 2.10 is that the percentage of patients who have been in the state psychiatric hospitals for a longer time (1 or more years) may be decreasing. There may be a relationship between the SOF Agreement Type (described in Chapter 1), the decreased percentages of patients who have long lengths of stay, and the increased percentages of patients with less than one year length of stay. The number of total patients admitted has decreased every year across the four years shown in Figure 2.10. Those patients who were admitted stayed a shorter length of time, which may mean there are more patients treated in each of the long-term beds that remain.

QUALITY ASSURANCE

The Division of Mental Health and Addiction acts as the purchaser and an oversight body for community-based services, rather than a direct service provider. As such, it is highly concerned with the quality of services offered by the community providers as well as the state psychiatric hospitals. In order to ensure quality service, the following efforts have been undertaken.

- **Site Visits to Managed Care Providers:** Enrollment and service data is analyzed periodically to examine patterns of service delivery and utilization. Those MCPs with data that fall far outside the norm are considered outliers and their information is then scrutinized more closely. Service data is also reviewed to assure that the proper level of service is being provided to an individual based on their clinical profile. If there are enrollment or service figures that appear questionable, a site visit and review by DMHA staff is conducted.
- **Audits:** Two instruments are used to assess consumer level of functioning and to determine the correct enrollment category for the client in the HAP—the Hoosier Assurance Plan Instrument for Adults (HAPI-A) and the Hoosier Assurance Plan Instrument for Children (HAPI-C). The HAPI-C is a new instrument, designed to improve the reliability of the functioning assessment of children. To ensure the integrity and reliability of these instruments, the DMHA contracts with KPMG Peat Marwick to conduct annual audits. A provider who does poorly on an audit will be audited again the following year. In SFY 2001, audits were expanded to include service data. Although several providers did poorly on audits during the biennium, none had to be sanctioned.
- **Provider Profile Report Cards:** Reports are published annually by DMHA that assess provider effectiveness in delivery of services, accessibility to services, and consumer perceptions of acceptability and satisfaction. Reports are published for each special population and are intended to help consumers choose mental health services that meet their needs. All MCPs that receive DMHA funding are included. The data is gathered by using the Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey, adopted not only by Indiana but by many other states.
- **Consumer Service Line:** The Marion County Mental Health Association (MCMHA) staffs a consumer service phone line for persons receiving services from DMHA contracted providers. The phone line, which is available Monday through Friday from 8:30 a.m. to 5:00 p.m., is 800-901-1133 (voice and TDD). This line was initiated in 1994 in response to mental health reform legislation as an easy, cost-free mechanism to give consumers direct access to the DMHA to register feedback about services received. This telephone line continues to provide useful information regarding consumers' perception of their treatment. The DMHA uses the call information to respond and intervene when needed to assist both consumers and MCPs in understanding and resolving disputes. Beginning in SFY 2003, the Indiana Council on Problem Gambling will staff this line.
- **Health Care Excel Audits:** The DMHA contracts with Health Care Excel (HCE) to assist in evaluating issues around community treatment. Audits can be at the request of a provider or generated by a consumer complaint. Audits may also occur as a result of unusual data findings. The audits take place on-site with a review of charts, records, and an interview of the concerned parties.

A determination is made as to whether the questioned action was appropriate, reasonable, and in line with existing policies, procedures, and practices.

- **Hospital Accreditation:** The six state psychiatric hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and maintain certification of all Intermediate Care Facilities for the Mentally Retarded (ICF/MR). To maintain JCAHO accreditation, all hospitals are required to participate in ORYX, a performance measurement program. This is accomplished through participation in the National Research Institute Performance Measurement System, which provides a framework within which the state psychiatric hospitals can identify and implement consistent measures of performance and outcome. Such consistent measurement produces the ability to benchmark the critical measures of performance and outcome, leading to the identification and implementation of processes that will ultimately improve client outcomes.
- **State Psychiatric Hospital Satisfaction Surveys:** Satisfaction surveys are sent to all patients upon their discharge from a state psychiatric hospital. For children and adolescents, surveys are sent to the parent/guardian. In addition to being used locally to monitor program acceptance and customer relations, a copy is sent to DMHA where statistical analyses are run comparing the hospitals and identifying particular strengths and weaknesses. Survey questions address program effectiveness, availability and cooperation of staff, treatment team meetings, treatment outcomes, safety, and more. Survey results are discussed with each hospital at quarterly governing body meetings and hospitals are expected to study and report on problem areas. Hospitals that score significantly below other hospitals on an item must develop strategies focused on improvement.